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Community Impact Analysis of the Proposed Conversion of CareFirst, Inc. to a For-Profit Business Entity and the Merger Between CareFirst, Inc. and WellPoint Health Networks Inc.

January 2002

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January 10, 2002

William L. Jews
President and Chief Executive Officer
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, Maryland 21117

Dear Mr. Jews:

You have requested that Accenture prepare a Community Impact Analysis report (hereinafter, the "Report") for CareFirst BlueCross BlueShield ("CareFirst").

The objective of our Report will be to help you to assess the probable effects of CareFirst's conversion to a for-profit business entity and merger with WellPoint Health Networks Inc., upon the availability, accessibility, and affordability of health care for the citizens of Maryland, Delaware and Washington, D.C. We have conducted this analysis at CareFirst's request. We understand that CareFirst, should it choose to do so, will submit the Report to the State of Maryland as part of an application under Section 6.5-201 of the State Government Article, Annotated Code of Maryland to seek approval for the proposed conversion and merger, and may choose to submit this report to Delaware and Washington, D.C. as part of its filings to those jurisdictions as well. The analysis covers only part of what CareFirst is required to submit in order to gain approval and we have assumed that materials to address the remaining requirements of applicable laws and regulations will supplement it.

This report has been prepared for the specific objective described above and is intended for no other purpose.

Please feel free to contact us regarding any follow-up required to this Report.

Best regards,

Joe Marabito
Partner
Accenture

Community Impact Analysis

Covering CareFirst BlueCross BlueShield's Conversion to a For-Profit Business Entity and Merger with WellPoint Health Networks Inc.

Table of Contents

OCC 003704

I. Purpose of the Community Impact Analysis

The purpose of this section is to state the objective of this report, to present definitions of relevant terms, and to state Accenture's relationships with the parties involved in the proposed transaction.

Accenture was retained by CareFirst to prepare a Community Impact Analysis report (hereinafter, the "Report") for CareFirst and its non-profit operating subsidiaries (collectively, "CareFirst"). The objective of the Report is to determine the probable impact upon the availability, accessibility and affordability of health care in the primary communities served by CareFirst of a conversion of CareFirst from a non-profit business entity to a for-profit business entity and a merger with WellPoint Health Networks Inc. (hereinafter, "WellPoint").

For the purposes of this Report, the primary communities served by CareFirst are taken to be the populations of the states of Maryland and Delaware and Washington, D.C. The impacts we describe in this Report primarily affect CareFirst members, since this population most directly interacts with CareFirst. The impacts we describe in this Report secondarily affect the communities in which CareFirst operates because there may be changes to the health system resulting from CareFirst's proposed conversion and merger.

For the purposes of this Report, we use the following definitions of availability, accessibility and affordability:

- Availability: "The relationship of volume and type of existing services and resources to a person's volume and type of need." (see Penchansky and Thomas, "The Concept of Access - Definition and Relationship to Consumer Satisfaction" in Medical Care, XIX(2), 127 - 140)

- Accessibility: "The ability of a population or a segment of the population to obtain health services. This ability is determined by economic, temporal, locational, architectural, cultural, organizational and informational factors which may be barriers or facilitators to obtaining services." (Bureau of Health Planning, p.54 as cited in Khan and Bhardwaj, 1994, p. 63). For the purposes of this analysis, we focus on the economic, organizational and informational factors influencing accessibility, as they apply to the role of a health plan in conducting its business. The other factors influencing accessibility, including the temporal, locational, architectural and cultural factors, are more directly influenced by other participants in the delivery of health care (e.g., doctors, hospitals, home health care suppliers, etc.) and less likely to be influenced by a health plan.

- Affordability: "The relationship of the price of services to people's ability to pay for the services." (see Penchansky and Thomas, "The Concept of Access - Definition and Relationship to Consumer Satisfaction" in Medical Care, XIX(2), 127 - 140)

OCC 003705

It should be noted that Accenture also provides services to WellPoint. These services are not related to the proposed merger with CareFirst, and the team of Accenture personnel involved in preparing this Report is entirely separate from the team providing services to WellPoint. Neither Accenture nor any Accenture Partners involved in preparing this Report currently hold directly or indirectly (other than through the holding of mutual funds) or plan to acquire the stock of WellPoint during the timeframe of this transaction. While Accenture will receive a pre-arranged fee from CareFirst for the preparation of this

Report, the amount of the fee does not depend upon the approval or disapproval of the proposed transaction by the respective jurisdictions.

Accenture has previously worked with CareFirst to help CareFirst better understand trends within the health care industry and explore strategic options within the context of those trends. The most recent work Accenture has completed for CareFirst in this area was documented in the paper titled "An Assessment of Health Coverage Industry Trends and CareFirst's Strategic Response", published in November of 2001 and excerpted here in this Report, in the section titled Health Care Industry Context. "An Assessment of Health Coverage Industry Trends and CareFirst's Strategic Response" was produced prior to the announcement of CareFirst's intent to convert to for-profit status and merge with WellPoint.

We understand that CareFirst may choose to submit this Report to: (i) the Insurance Commissioner of the State of Maryland as part of an application under Section 6.5-201 of the State Government Article, Annotated Code of Maryland; (ii) the Insurance Commissioner and Corporation Counsel of Washington, D.C.; and (iii) the Insurance Commissioner and Attorney General of the State of Delaware. In the latter two jurisdictions the Report would be provided in connection with other filings relating to the conversion and merger, in order to assist those regulators in their review of the proposed CareFirst transaction. As this Report addresses the situation in two states and the District of Columbia, we have not prepared it against any specific legal or regulatory requirements and CareFirst is responsible for satisfying itself that the Report complies with the requirements of any particular law in any jurisdiction in which it is submitted.

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II. Company Background

The purpose of this section is to provide context on the history of CareFirst, Inc., and its non-profit operating subsidiaries.

CareFirst, Inc., is a not-for-profit holding company that operates through three wholly-owned subsidiaries: CareFirst of Maryland, Inc. (formerly Blue Cross Blue Shield of Maryland), Group Hospitalization and Medical Services, Inc. D/B/A CareFirst Blue Cross Blue Shield of the National Capital Area, and Blue Cross Blue Shield of Delaware. All three affiliates are independently licensed by the Blue Cross Blue Shield Association to market health insurance and related products throughout the Mid-Atlantic region including Maryland, Delaware, Washington, D.C. and portions of Northern Virginia.

The history of Blue Cross Blue Shield plans in Maryland begins in 1937, when fifteen community hospitals agreed to participate in the Associated Hospital Service of Baltimore and became authorized to use the Blue Cross service mark in Maryland. The focus of the Blue Cross plan was to provide pre-paid hospital services to Maryland residents during the depression and provide a steady source of income for the hospitals. In 1947, the Associated Hospital Service of Baltimore changed its name to Maryland Hospital Service in recognition of its expanded membership and hospital participation.

Maryland's Blue Shield plan was established in 1950, when Maryland Medical Service, a physician group, became incorporated and licensed to use the Blue Shield name to provide pre-paid physician services. In 1969, Maryland Hospital Service and Maryland Medical Services changed their names to Maryland Blue Cross and Maryland Blue Shield, respectively. These two Maryland Blues plans merged to form one company, Blue Cross and Blue Shield of Maryland, Inc., in 1984.

The history of Blue Cross Blue Shield in the Washington, D.C. area starts in 1942, when Group Hospitalization, Inc. a hospital association in Washington, D.C. founded in 1934, became authorized to use the Blue Cross service mark. Blue Shield was started in the area in 1952, when Medical Service of the District of Columbia became authorized to use the Blue Shield service mark. In 1985, Group Hospitalization and Medical Service of the District of Columbia merged to form Group Hospitalization and Medical Services, Inc. The trade name Blue Cross Blue Shield of the National Capital Area was adopted at the same time.

In Delaware, Group Hospital Service was incorporated in 1935 and, in 1941, became authorized to use the Blue Cross service mark. Two years later, in 1943, Group Hospital Service became authorized to offer Blue Shield coverage to Delaware residents as well. The name officially changed to Blue Cross Blue Shield of Delaware in 1965.

CareFirst, Inc., as it is known today was formed in January 1998, when Blue Cross Blue Shield of Maryland combined with Blue Cross Blue Shield of the National Capital Area. In 2000, CareFirst affiliated with Blue Cross Blue Shield of Delaware. CareFirst, Inc., is managed and controlled by its own Board of Directors and responsible for its own operations.

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CareFirst's mission statement reflects its ongoing commitment to provide health care services to the Mid-Atlantic community:

> *CareFirst shall be the leading regional health care company recognized for a comprehensive portfolio of high quality innovative products and administrative services. Our purpose is to provide the best value to our customers in partnership with the health care community and in an environment which promotes respect, fairness and opportunity for our associates.*

CareFirst provides health insurance benefits and services to approximately three million members. The Company offers both managed and indemnity health care insurance products through its Blue Cross Blue Shield plans, as well as other health services products through wholly-owned subsidiaries and non-Blue affiliations (See Appendix for Chart of Subsidiaries). Approximately 70% of CareFirst's membership is enrolled in a managed care product. CareFirst's managed care product portfolio includes: Health Maintenance Organizations, Preferred Provider Organizations, and Point of Service plans (See Appendix for Product Descriptions). The Company also offers traditional indemnity products, which account for the remaining proportion of its medical membership. CareFirst's primary source of revenue comes from health care premiums received through its medical insurance products. The Company reported total revenue of $5 billion in 2000, and net income of $63.8 million.

CareFirst is headquartered in Owings Mills, Maryland. CareFirst has over 30 additional offices located in Maryland, the District of Columbia, Delaware, Virginia, and North Carolina (See Appendix for Corporate Locations). The Company employs over 6,500 employees, which it calls associates.

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III. Financial Information

The purpose of this section is to provide background regarding CareFirst's financial performance over the recent past. The information for this section was obtained from publicly available sources and from CareFirst. The current year-to-date information was obtained through CareFirst. All of the financial information in this section is reported on a consolidated basis, and is in accordance with Generally Accepted Accounting Principles, i.e., GAAP.

CareFirst Year-to-Date 2001 – From January through September 2001

For the first nine months of 2001, total revenue, including premium and management services revenue, was $4.5 billion. Year-to-date, CareFirst medical expenses were 90.2% of premium revenue. Administrative expenses, as measured by administrative expenses divided by net revenue (total revenue minus investment revenue), was 9.0%.

Net income for the first nine months of 2001 was $72.7 million, resulting in a net profit margin (net income divided by total revenue) of 1.64%, an increase from the 1.23% margin reported for the same period in 2000. CareFirst management attributed the increase in net income percentage to the return on its investment, made over the last few years, in information technology (see below where IT investments contributed to impacts on net income in 1998). Reserves were $768.9 million. Reserves as a proportion of total revenues are 17.4%. Reserves are compliant with NAIC and BCBSA guidelines.

Historical Results

In March 2000, CareFirst became affiliated with the parent company of Blue Cross Blue Shield of Delaware (BCBSD). The affiliation was a "pooling of interest" transaction, and CareFirst has restated its consolidated financial statements for 1999 and 2000 as required, combining the results of CareFirst and BCBSD.

Prior financial statements were also restated to properly categorize CareFirst's Medicare and Medicaid HMO risk operations as a discontinued business segment, a decision that was made by CareFirst management in December 2000.

According to these restated financial statements, CareFirst's revenue grew at an annual rate of 12.1% over the period 1998 to 2000, reaching $5.0 billion in 2000. On average, the medical expense ratio was 89.5% of premium revenue and administrative expenses averaged 9.9% of total revenue less investment revenue.

Net income was $63.8 million in 2000, a decline of roughly sixteen percent from 1998, a trend that management primarily attributes to investments in information technology and to operating losses associated with certain public sector programs. CareFirst recorded $691.8 million in reserves in 2000. CareFirst's reserves averaged 13.1% of revenue over the 1998-2000 period.

Membership growth has driven revenue growth for CareFirst. Affiliations have been the significant source of membership growth for CareFirst. Total medical membership, including indemnity and managed care, increased by approximately 660,000 members over the period 1998 to 2000, to reach three million in 2000. This represents an annual growth rate of over 13%.

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IV. Health Care Industry Context

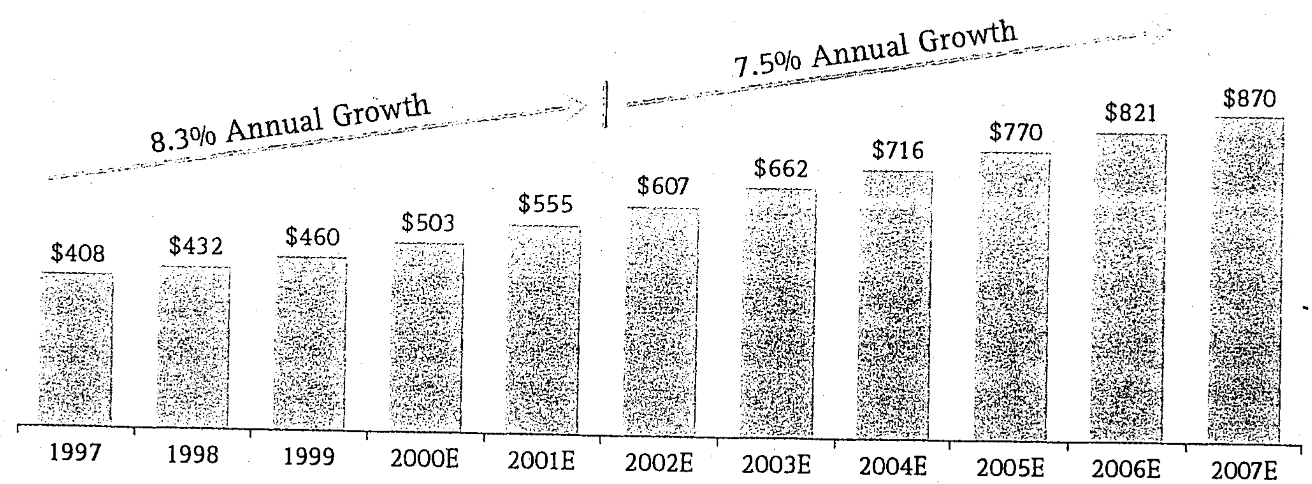
The purpose of this section is to provide context on the national and local market forces influencing health plans, and why we believe the proposed transaction is strategic to CareFirst.

The following information is excerpted from "An Assessment of Health Coverage Industry Trends and CareFirst's Strategic Response", a paper Accenture produced in November 2001 assessing CareFirst's current situation and the options CareFirst has available in order to continue serving its constituents over the long term.

Health plans are being squeezed—rising healthcare costs, state and federal mandates, changing technologies, and increasing customer expectations have narrowed health plan margins, while simultaneously accelerating investment requirements in their base business.

According to government estimates, national private healthcare costs have increased 8.3% annually, on average, over the past five years. In addition, complex regulatory mandates—most recently the Healthcare Insurance Portability and Accountability Act (HIPAA)—require significant investment by health plans.

Private Health Care Expenditures
(Excluding Research and Construction, $ in Billions)



Source: Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration), *National Health Expenditure Projections, 2000-2010*, March 2001.

As a result, health plans have been forced to increase healthcare premiums significantly since 1996, with double-digit increases nationally over the past two years.

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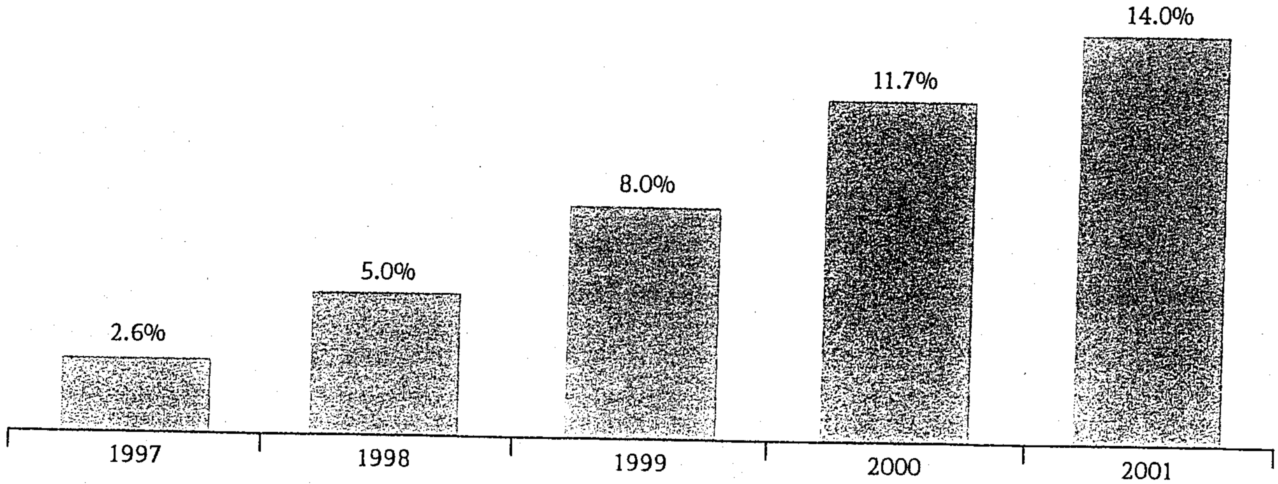
HMO/POS Rates, Percent Increase in Average Per Employee Premium
(Fully Insured Plans only)



Source: Credit Suisse First Boston, *Benefit Manager Survey*, January 30, 2001.

At the same time, health plans are trying to lessen the financial impact on customers, while enhancing the products they deliver. To mitigate rising costs, and to meet increasing consumer demands, health plans are investing in new technologies, introducing new products, and improving basic systems and processes. Furthermore, in order to improve their competitiveness, health plans have also been actively consolidating. Estimates for the cost of these investments-including HIPAA compliance–for large health plans range from $420-$640 million, and possibly more, over the next five years.

Estimated Average Health Plan Investment Needs in the Next 3-5 Years*
(For Large Health Plans with Revenues > $500 Million)

Area	Low	High
HIPAA (Health Insurance Portability and Accountability Act)	$ 30	$ 60
eCommerce	$ 10	$ 40
Consumer-focused Initiatives	$ 20	$ 40
IT Infrastructure Improvements	$ 30	$ 50
Merger and Acquisition Activity**	$330	$450
Other (e.g., merger integration expenditures, partnerships/ interconnectivity, potential future regulations, etc.)	Additional	Additional
Total Investment ($ in Millions)	$420+	$640+

* Estimates based on industry analyst projections and current market conditions; may evolve given new information over time.

** Estimates based on the average actual cash expended on mid-range health plan acquisitions since 1997, screened against available merger candidates in CareFirst's markets.

Source: Gartner Research, *2000 Payer IT Budget and Staffing Survey*, August 14, 2001; Gartner Research, *2000 IT Spending and Staffing Survey*, October 2, 2000; SEC filings; Company press releases; merger news articles; Accenture analysis, surveys and client experience.

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